1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13765

## CERTIFICATE OF DEATH

Reg. Dist. No. 13735

1. PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): La Plata
c. LENGTH OF STAY IN 1b: 3 Months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X La Plata
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CHARLES Middle CLIFFORD Last BARBER

4. DATE OF DEATH: Month Dec Day 4 Year 1960

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: August 21, 1960
9. AGE (In years last birthday) yrs.
IF UNDER 1 YEAR: Months 5 Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Chrles County, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Edward Barber
14. MOTHER'S MAIDEN NAME: Evelyn Barber

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
INFORMANT Address: Mr.s Evelyn Barber - La Plata, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days.
493X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12-1, 1960, to 12-4, 1960, that I last saw the deceased alive on 12-1, 1960, and that death occurred at 6 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: F M Johnson M.D. ADDRESS (Street, city or town, state): LA PLATA, Md. DATE SIGNED: 12-4-60

PHYSICIAN'S NAME (Type): F. M. Johnson, M.D. La Plata, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/5/1960
22c. NAME OF CEMETERY OR CREMATORY: Sacred Heart Cemetery
22d. LOCATION (City, town, or county) (State): La Plata, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Arehart Funeral Home, Inc.
ADDRESS: Arehart Funeral Home, Inc. - La Plata, Md.
24a. REC'D BY REGISTRAR DATE: DEC 6 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
TSM 9/58

4000181 X V 4

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 FilmG277 12-21-60 et

13766

# CERTIFICATE OF DEATH

Reg. Dist. No. 13736

1. PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Indian Head Md
c. LENGTH OF STAY IN 1b: 30-Yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Indian Head Md
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Harry Lee — Middle: Besley — Last:
4. DATE OF DEATH: Month: 12-8-60 — Day — Year: 19

5. SEX: Male
6. COLOR OR RACE: W-US
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5-28-1896
9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist
10b. KIND OF BUSINESS OR INDUSTRY: Maintainance
11. BIRTHPLACE (State or foreign country): Spencer, New York
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Ruben Besley
14. MOTHER'S MAIDEN NAME: Bertha Lawrence

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Yes (If yes, give war or dates of service): USMC
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address: Edgar Besley (Brother) Indian Head Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma Pancreas With Liver Metastesis — INTERVAL BETWEEN ONSET AND DEATH: Indefinite
157X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Malnutrition due to liver involvement
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-10-60, 19__ to 12-8-60, 19__, that I last saw the deceased alive on 12-8-60, 19__, and that death occurred at 5-PM M, from the causes and on the date stated above.

ACTUAL SIGNATURE: James E. Andrews M.D. — ADDRESS (Street, city or town, state): Indian Head Md — DATE SIGNED: 12-9-60

PHYSICIAN'S NAME (Type): James E. Andrews MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12-12-60
22c. NAME OF CEMETERY OR CREMATORY: Fort Foote
22d. LOCATION (City, town, or county) (State): Washington D.C.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Hoyt Funeral Home Waldorf Md
24a. REC'D BY REGISTRAR — DATE: DEC 15 '60
24b. REGISTRAR'S SIGNATURE: Luther S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13767

## CERTIFICATE OF DEATH

13737 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Charles MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Newport
c. LENGTH OF STAY IN 1b 16 yrs
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Newport
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First THOMAS Middle Last BOWMAN

4. DATE OF DEATH Month Dec Day 7 Year 1960

5. SEX M.

6. COLOR OR RACE C

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH 6-5-1884

9. AGE (In years last birthday) 76 yrs.

IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming

10b. KIND OF BUSINESS OR INDUSTRY Farm

11. BIRTHPLACE (State or foreign country) Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Steven I. Bowman

14. MOTHER'S MAIDEN NAME Mary J. Thomas

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

INFORMANT Address William H. Bowman 4236 Bennington Rd NE Washington 16 D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic Carcinoma of undetermined origin 1 year
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
199.2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 1959, to Dec 6, 1960, that I last saw the deceased alive on July, 1960, and that death occurred at _____ M, from the causes and on the date stated above.

ACTUAL SIGNATURE F. N. Johnson M.D.

ADDRESS (Street, city or town, state) LA PLATA, Md.

DATE SIGNED 12-7-60

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF 12/10/60

22c. NAME OF CEMETERY OR CREMATORY St. Mary's

22d. LOCATION (City, town, or county) (State) Newport, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS W. Clarke Mattingley Leonardtown, Maryland

24a. REC'D BY REGISTRAR DATE DEC 12 '60

24b. REGISTRAR'S SIGNATURE Arthur S. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13768

## CERTIFICATE OF DEATH

Reg. Dist. No. 13738

1. PLACE OF DEATH
a. COUNTY CHARLES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAPLATA
c. LENGTH OF STAY IN 1b 1 days.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PHYSICIANS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY CHARLES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural PISGAH
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First THOMAS Middle DEWEY Last CARPENTER

4. DATE OF DEATH Month DECEMBER Day 21 Year 1960

5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 8/15/1897
9. AGE (In years last birthday) 63 yrs.
IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attendent
10b. KIND OF BUSINESS OR INDUSTRY U.S. Government
11. BIRTHPLACE (State or foreign country) Charles Co., Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Charles D. Carpenter
14. MOTHER'S MAIDEN NAME Sarah A. Braguner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. No
INFORMANT Address: Mrs. Cecelia B. Carpenter - Pisgah, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Respiratory Collapse — INTERVAL BETWEEN ONSET AND DEATH 6 hrs
420.7
DUE TO (b) Myocardial infarction. — 28 hrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c) Hypertensive heart disease — 2 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from 20 Dec, 19 60, to 21 Dec, 19 60, that I last saw the deceased alive on 21 Dec, 19 60, and that death occurred at 7:5X M, from the causes and on the date stated above.

ACTUAL SIGNATURE J Woody MD M.D. — ADDRESS (Street, city or town, state) Harwood Clinic — DATE SIGNED 21 Dec 60
PHYSICIAN'S NAME (Type) La Plata Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 12/23/1960
22c. NAME OF CEMETERY OR CREMATORY Pisgah Methodist Cemetery
22d. LOCATION (City, town, or county) (State) Pisgah, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE Earhart Funeral Home, Inc. ADDRESS Earhart Funeral Home, Inc. La Plata, Md.
24a. REC'D BY REGISTRAR DATE DEC 30 '60
24b. REGISTRAR'S SIGNATURE Esther S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13769

## CERTIFICATE OF DEATH

Reg. Dist. No. 13739

1. PLACE OF DEATH
a. COUNTY Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Dentsville
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) First Philip Middle Alexander Last Cusick

4. DATE OF DEATH Month Dec. Day 8, Year 1960

5. SEX Male

6. COLOR OR RACE White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH Sept. 22, 1778

9. AGE (In years last birthday) 82 yrs.
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer

10b. KIND OF BUSINESS OR INDUSTRY Farming

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William Cusick

14. MOTHER'S MAIDEN NAME Lucy Kaywood

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Harry Cusick, Address Newport, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH 12-8-60
420.1
DUE TO (b) Glu Left Sel
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 11-2-, 1960, to 12-8-, 1960, that I last saw the deceased alive on 12-7-, 1960, and that death occurred at 1 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE [signature] M.D.
ADDRESS (Street, City or town, state) La Plata Md.
DATE SIGNED
PHYSICIAN'S NAME (Type) F. J. EDELEN

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF 12-12-60

22c. NAME OF CEMETERY OR CREMATORY St Peters

22d. LOCATION (City, town, or county) (State) Waldorf, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS The Huntt Funeral Home, Waldorf, Md.

24a. REC'D BY REGISTRAR DATE DEC 15 '60

24b. REGISTRAR'S SIGNATURE Clifton L. Hanna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

13770

13740

1 PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): La Plata
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Physicians Memorial Hosp.

2 USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission)
a. STATE: Md. b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Waldorf.
d. STREET ADDRESS: Rt 2 Box 76 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: INEZ Middle: V. Last: DAVIS

4. DATE OF DEATH: Month: DEC Day: 13 Year: 1960

5 SEX: Female

6 COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JAN 7 1926

9 AGE (In years last birthday): 34 yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): MARYLAND

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Morris Mc Cready

14. MOTHER'S MAIDEN NAME: Elsie Coleman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17 INFORMANT: Address: ARTHUR DAVIS, WALDORF, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Generalized Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 9 MOS.

DUE TO (b): SCE of Endocervix — 1 YR.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): 1717

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from Feb 1960 to Dec 13 1960 that (I) (we) last saw the deceased alive on Dec 12 1960, and that death occurred at 4:15 M, from the causes and on the date stated above

22a SIGNATURE: J. Parran Jarboe M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS ☐

22b DATE SIGNED

22c PHYSICIAN'S NAME (Type): J. PARRAN JARBOE MD

22d ADDRESS: La Plata, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b DATE THEREOF: 12-16-60

23c NAME OF CEMETERY OR CREMATORY: Trinity Memorial

23d LOCATION (City, town, or county) (State): WALDORF, MD.

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: The Hunter Funeral Home, Waldorf, Md.

25a. REC'D BY REGISTRAR DATE: DEC 22 60

25b. REGISTRAR'S SIGNATURE: Luther S. House

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 1SM 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1377 Reg. Dist. No. 12747

1. PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hughesville
c. LENGTH OF STAY IN 1b: 17 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Md. b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hughesville
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Annie Middle: Gertrude Last: Dean
4. DATE OF DEATH: Month: 12 Day: 14 Year: 1960
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 7-9-93
9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Oscar T. Williams
14. MOTHER'S MAIDEN NAME: ? ?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: William L. Dean Address: Hughesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardio Vas Renal Disease — INTERVAL BETWEEN ONSET AND DEATH: 12-14-60
442x
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☒, and find that death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: C. V. Hodgdon M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): C. V. HODGDON
DATE SIGNED: 12-14-60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/17/60
22c. NAME OF CEMETERY OR CREMATORY: St Mary's
22d. LOCATION (City, town, or county) (State): Mongomery Md

23. FUNERAL DIRECTOR'S SIGNATURE: McLain Mattingley ADDRESS: Leonardtown, Md
24a. REC'D BY REGISTRAR DATE: DEC 20 '60
24b. REGISTRAR'S SIGNATURE: C. Irving Evans

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

1

**FOR STATE HEALTH DEPT.**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13772

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Physicians Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) 13772
a. STATE Md. b. COUNTY Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hughesville
d. STREET ADDRESS Rural
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First: BARRETT Middle: GREGORY Last: DOUGLAS
4. DATE OF DEATH Month: 12 Day: 14 Year: 1960
5. SEX M
6. COLOR OR RACE C
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 5-12-60
9. AGE (In years last birthday) yrs. IF UNDER 1 YEAR Months: 7 Days: 24 IF UNDER 24 HRS. Hours: Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Columbus Brown
14. MOTHER'S MAIDEN NAME Mary Catherine Douglas
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No
16. SOCIAL SECURITY NO. none
17. INFORMANT Address: Physicians Memorial Hospital

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). Bronchial Pneumonia — INTERVAL BETWEEN ONSET AND DEATH 12-14-60
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE [signature] M.D.
EXAMINER'S NAME (Type) E. J. Eppley
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)
DATE SIGNED 12-14-60

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 12/19/1960
22c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery
22d. LOCATION (City, town, or country) La Plata, Maryland (State)

23. FUNERAL DIRECTOR ADDRESS Arehart Funeral Home, Inc. La Plata, Md.
24a. REC'D BY REGISTRAR DATE DEC 20 '60
24b. REGISTRAR'S SIGNATURE [signature]

1

FOR STATE HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13773 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 13743

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME 5M 7/59

1. PLACE OF DEATH
   a. COUNTY: CHARLES — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BRYANS RD
   c. LENGTH OF STAY IN 1b
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Md.
   b. COUNTY: Charles
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bryans Road
   d. STREET ADDRESS
   e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First RANDOLPH Middle Last FUREY

4. DATE OF DEATH: Month 12 Day 15 Year 1960

5. SEX: M

6. COLOR OR RACE: C

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 8-15-1899

9. AGE (In years last birthday): 61 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Fr. Farm

11. BIRTHPLACE (State or foreign country): St. Thomas, V.I.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ? Deceased

14. MOTHER'S MAIDEN NAME: ? Deceased

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Frank T. Furey — Bryans Road Md. (Address)

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CORONARY Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 12-15-60
DUE TO (b): 4 20.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [✓], Inquiry [✓] and in my opinion death resulted from: Natural causes [✓] Accident [ ] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE: E. J. Edelen M.D.

EXAMINER'S NAME (Type): E. J. EDELEN

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [✓]

Address (Street, city, town, or county)

DATE SIGNED: 12-15-60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12-20-60

22c. NAME OF CEMETERY OR CREMATORY: Metropolitan Methodist

22d. LOCATION (City, town, or country) (State): Pomonkey, Md.

23. FUNERAL DIRECTOR: Barnes-Matthews — ADDRESS: 3619-14th St. N.W. Wash. D.C.

24a. REC'D BY REGISTRAR DATE: DEC 19 '60

24b. REGISTRAR'S SIGNATURE: Viola S. Knaus

1

FOR STATE HEALTH DEPT.

M

I

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14597

1. PLACE OF DEATH
a. COUNTY: CHARLES
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): GRAYTON (rural) life
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institutions: Residence before admission)
a. STATE: Maryland
b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Grayton
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First SARAH Middle LOUISE Last GASSAWAY

4. DATE OF DEATH: Month DECEMBER Day 2 Year 1960

5. SEX: F

6. COLOR OR RACE: C

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7/5/60

9. AGE (In years last birthday): yrs. IF UNDER 1 YEAR: Months 4 Days 27 IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Char. Co. Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ARTHUR GASSAWAY

14. MOTHER'S MAIDEN NAME: MARY BERTHA HENSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: FATHER, GRAYTON, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Prob. Pneumonia
DUE TO
(b) Had minor respiratory ailment for 2 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH: 1 2-2-'60

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Found dead in bed at 2 A.M. on 12-2-'60

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: E.J. Edelen

EXAMINER'S NAME (Type): E.J.EDELEN

M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county):

DATE SIGNED: 12-2-'60

22a. BURIAL, CREMATION, REMOVAL (Specify):

22b. DATE THEREOF:

22c. NAME OF CEMETERY OR CREMATORY:

22d. LOCATION (City, town, or country) (State):

23. FUNERAL DIRECTOR: Father ADDRESS: Grayton, Md.

24a. REC'D BY REGISTRAR DATE APR 17 '61

24b. REGISTRAR'S SIGNATURE: Arthur L. Kinna

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and to any shipment within 24 hours after death.

VS. A15ME 5M 9/60

4/10/61 mnb

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

13774 — Reg. Dist. No. 13746

1. PLACE OF DEATH
a. COUNTY: CHARLES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LA PLATA
c. LENGTH OF STAY IN 1b: 7 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: CHARLES MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL - Ironside - Grayton
d. STREET ADDRESS: Route 1 Box 59 Nanjemoy
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First RICHARD — Middle M. — Last GOLDEN

4. DATE OF DEATH: Month DEC — Day 25 — Year 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 2/17/1889

9. AGE (In years last birthday): 71 yrs

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mailman - farm

10b. KIND OF BUSINESS OR INDUSTRY: U S Govt

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Fuller S. Golden

14. MOTHER'S MAIDEN NAME: Catherine Willett

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 217-36-6235

INFORMANT: WIFE — NAME E. GOLDEN — Address: Route 1 Box 59 Nanjemoy, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Respiratory Collapse — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs.

490X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (b): Pneumonia, Lobar — 7 days

DUE TO (c): Upper respiratory infection — 4 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): PARKINSON SYNDROME

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 19 49, to Dec 25, 19 60, that I last saw the deceased alive on 25 Dec 1960, and that death occurred at 12:00 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: A. S. Woodby M.D. — ADDRESS (Street, city or town, state): Sarwood Clinic — DATE SIGNED: 25 Dec 60

PHYSICIAN'S NAME (Type): Arthur S. Woodby — La Plata Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12/27/1960

22c. NAME OF CEMETERY OR CREMATORY: Nanjemoy Baptist Church

22d. LOCATION (City, town, or county) (State): Nanjemoy, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Arehart Funeral Home, Inc. — ADDRESS: Arehart Funeral Home, Inc. - La Plata, Md.

24a. REC'D BY REGISTRAR DATE: DEC 30 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Knauf

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/SB

FOR STATE HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 13775 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13745

1. PLACE OF DEATH
a. COUNTY: CHARLES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WALDORF
c. LENGTH OF STAY IN 1b: TRANS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): NONE

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: D.C. — b. COUNTY: 47X
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WASHINGTON
d. STREET ADDRESS: 2108 I ST N.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: CARL — Middle: Luther — Last: HEADEN

4. DATE OF DEATH: Month: Dec — Day: 9 — Year: 1960

5. SEX: M

6. COLOR OR RACE: C

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JULY 1939

9. AGE (In years last birthday): 21 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): NORTH CAROLINA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CLAUDE HEADEN

14. MOTHER'S MAIDEN NAME: CALLIE HEART

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): Unknown

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: ROLAND HEADEN — Address: PITTSBORO NC.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 1 X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

(a) COMPOUND FRACTURE SKULL
(b) MULTIPLE FRACTURES of Legs

INTERVAL BETWEEN ONSET AND DEATH: 12 9-60

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I:

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): PEDESTRIAN Hit By Auto 12 9-60

20c. TIME OF INJURY: Hour: 11 a.m. p.m. — Month, Day, Year: 12-9-1960

20d. INJURY OCCURRED: While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Hwy

20f. (City or town): WALDORF (County): CHAS (State): MD

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: [signature] M D

EXAMINER'S NAME (Type): F S EDELEN

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county): DATE SIGNED: 12-9-60

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 12-15-60

22c. NAME OF CEMETERY OR CREMATORY: UNION GROVE

22d. LOCATION (City, town, or country): PITTSBORO (State): N.C.

23. FUNERAL DIRECTOR: HUNTT FUNERAL HOME — ADDRESS: WALDORF Md

24a. REC'D BY REGISTRAR: DATE DEC 15 '60

24b. REGISTRAR'S SIGNATURE: Luther S. Frank

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1

**FOR STATE HEALTH DEPT.**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13776 13746

1. PLACE OF DEATH
a. COUNTY Charles
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MALCOLM
c. LENGTH OF STAY IN MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, If inst tut on Residence before adm ssion)
a. STATE Md b. COUNTY Charles
c. CITY OR TOWN (If outs de corporate limits, write RURAL and g ve nearest town) Brandywine
STREET ADDRESS Box 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Guy Middle D Last Henson

4. DATE OF DEATH Month 12 Day 11 Year 19 60

5. SEX M

6. COLOR OR RACE C

7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH 5/15/1912

9. AGE (In years last birthday) 48 yrs.

IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Benjamin Henson

14. MOTHER'S MAIDEN NAME Carrie Monroe

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) SHOCK — INTERVAL BETWEEN ONSET AND DEATH 12 11-60

DUE TO (b) Compound Fx Skull — 12-11-60

DUE TO (c) Pedestrian Hit By Auto — 12-11-60

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☑ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hit By Auto

20c. TIME OF INJURY Hour 1 a.m. Month, Day, Year 12-11 19 60

20d. INJURY OCCURRED While at work ☐ Not While at work ☑

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway

20f. (City or town) Malcolm (County) Chas (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☑, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE E. J. Adelsen M.D

EXAMINER'S NAME (Type) E. J. Adelsen

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑

Address (Street, city, town, or county)

DATE SIGNED 12-11-60

22a. BURIAL, CREMATION, REMOVAL (Specify) Buried

22b. DATE THEREOF 12/13/60

22c. NAME OF CEMETERY OR CREMATORY St. Thomas

22d. LOCATION (City, town, or country) Brandywine (State) Md.

23. FUNERAL DIRECTOR George H. Nelson

ADDRESS Aquasco Md

24a. REC'D BY REGISTRAR DEC 19 '60

24b. REGISTRAR'S SIGNATURE Arthur S. Hewitt

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13777

## CERTIFICATE OF DEATH

13747

**1 PLACE OF DEATH**
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Waldorf
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: none

**2. USUAL RESIDENCE** (Where deceased lived. If institution, Residence before admission)
a. STATE: Md.
b. COUNTY: Charles
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Waldorf
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Edith — Middle: Laws — Last:

**4. DATE OF DEATH**: Month: December — Day: 18 — Year: 1960 19

**5. SEX**: F

**6. COLOR OR RACE**: W

**7** MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

**8. DATE OF BIRTH**: Aug. 28, 1885

**9. AGE** (In years last birthday): 75 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Housework

**10b. KIND OF BUSINESS OR INDUSTRY**: —

**11. BIRTHPLACE** (State or foreign country): Va.

**12. CITIZEN OF WHAT COUNTRY?**: USA

**13. FATHER'S NAME**: Samuel Laws

**14. MOTHER'S MAIDEN NAME**: UNK

**15. WAS DECEASED EVER IN U. S. ARMED FORCES?** (Yes, no, or unknown): no (If yes, give war or dates of service)

**16. SOCIAL SECURITY NO.**: 578-44-3644

**17 INFORMANT**: Mrs. T. H. Medley — Address: Waldorf, Md.

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Pneumonia, Terminal — INTERVAL BETWEEN ONSET AND DEATH: 4 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
DUE TO (b): Diabetes Mellitus
DUE TO (c): Senility

260 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

MEDICAL CERTIFICATION

**20a** ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b** DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

**20c.** TIME OF INJURY: Hour a. m. p. m. — Month — Day — Year 19

**20d.** INJURY OCCURRED: While at work ☐ Not while at work ☐

**20e.** PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

**20f** (City or town) (County) (State)

**21** I certify that (I) (this hospital) attended the deceased from Dec 14 19 to Dec 18 1960, that (I) (we) last saw the deceased alive on Dec 18 1960, and that death occurred at 12 M. from the causes and on the date stated above.

**22a** SIGNATURE: [signature] M.D

ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

**22b.** DATE SIGNED: 12-20-60

**22c** PHYSICIAN'S NAME (Type): George Weber M.D.

**22d.** ADDRESS: Waldorf, Md.

| 23a BURIAL, CREMATION, REMOVAL (Specify) | 23b DATE THEREOF | 23c NAME OF CEMETERY OR CREMATORY | 23d LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12 21 60 | St. Peters Cemetery | Waldorf, Md. |

| 24. FUNERAL DIRECTOR'S SIGNATURE | ADDRESS | 25a REC'D BY REGISTRAR DATE | 25b REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Huntt Funeral Home | Waldorf, Md. | DEC 27 '60 | Arthur S. Krauss |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13778

## CERTIFICATE OF DEATH

Reg. Dist. No. 12748

1. PLACE OF DEATH
a. COUNTY: Charles — MARYLAND

2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission)
a. STATE: Maryland Charles b. COUNTY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LaPlata Md.

c. LENGTH OF STAY IN 1b: 3-Days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Indian Head Md X

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Physicians Memorial Hosp. LaPlata Md

d. STREET ADDRESS: 32 E Riverview Village Indian Head Md

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Ruth Margeret Middle Manes Last

4. DATE OF DEATH: Month 12 Day 29 Year 60 19

5. SEX: Female

6. COLOR OR RACE: W-US

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12-30-97

9. AGE (In years last birthday): 62 yrs

IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House-Wife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: David O. Crouch

14. MOTHER'S MAIDEN NAME: Missouri Goodhart

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Madge Manes-Daughter Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma Liver, Primary — INTERVAL BETWEEN ONSET AND DEATH: Indefinite

155.2

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b):

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Malnutrition

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6-1-54, 19____, to 12-29-60, 19____, that I last saw the deceased alive on 12-29-60, 19____, and that death occurred at 3-32A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: James E. Andrews M.D. ADDRESS (Street, city or town, state): Indian Head Md DATE SIGNED: 12-29-60

PHYSICIAN'S NAME (Type): James E. Andrews

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 1/3/1961

22c. NAME OF CEMETERY OR CREMATORY: Arlington Natl Cem.

22d. LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Chehart Funeral Home-LaPlata, Md

24a. REC'D BY REGISTRAR DATE: JAN 3 '61

24b. REGISTRAR'S SIGNATURE: Andrews & Kime

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

FOR STATE HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 1377 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LA PLATA MD. (Rural)
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address, e. STREET ADDRESS): 1 Rural

2. USUAL RESIDENCE (Where deceased lived, If institution, residence before admission) — 13749
a. STATE: Maryland
b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): La Plata
d. STREET ADDRESS: 1 Rural
• IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First DANIEL Middle ORVILLE Last MARSHALL
4. DATE OF DEATH: Month 12 Day 16 Year 19 60
5. SEX: M
6. COLOR OR RACE: C
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 5-14-08
9. AGE (In years last birthday): 52 yrs. IF UNDER 1 YEAR Months / Days; IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: On farm.
11. BIRTHPLACE (State or foreign country): Md. U.S.A.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: DANIEL MARSHALL
14. MOTHER'S MAIDEN NAME: CORDELIA HAWKINS
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No.
16. SOCIAL SECURITY NO.: Unknown.
17. INFORMANT: Ethel Gray
Address: 1234 L.St. N.E.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): 420.1
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: 12-16-60

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X] and in my opinion death resulted from: Natural causes [X] Accident [ ] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE: C. J. Adelsberger M.D.
EXAMINER'S NAME (Type): E. J. FEIFEL
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
Address (Street, city, town, or county)
DATE SIGNED: 12-16-60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Dec-20-1960
22c. NAME OF CEMETERY OR CREMATORY: National Harmony Memorial Park
22d. LOCATION (City, town, or country) (State): Washington, D. C.

23. FUNERAL DIRECTOR: John T. Rhines & Co.
ADDRESS: 3015 12th Street, N. E.
24a. REC'D BY REGISTRAR DATE: DEC 22 '60
24b. REGISTRAR'S SIGNATURE: Carling L. Krause

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any d... necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the fun... ector. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 13780 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 1 filing 1-3-61 et — 13750

1. PLACE OF DEATH
a. COUNTY Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pisgah (Rural)
c. LENGTH OF STAY IN 1b Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE Md. b. COUNTY Charles
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Pisgah Md. (Rural)
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First ARTHUR Middle Last MONROE

4. DATE OF DEATH Month 12 Day 17 Year 1960

5. SEX M

6. COLOR OR RACE C

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH 3-31-91

9. AGE (In years last birthday) 69 yrs IF UNDER 1 YEAR Months / Days IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None

10b. KIND OF BUSINESS OR INDUSTRY Powder Factory

11. BIRTHPLACE (State or foreign country) Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME GEORGE MONROE

14. MOTHER'S MAIDEN NAME Lucretia Miles

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No

16. SOCIAL SECURITY NO. 577-26-7267

17. INFORMANT Address Bertha Diggs Pisgah Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH 12-14-60
DUE TO (b) 260 X — 12-17-60
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Diabetes

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE E. H. Adelman M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑

EXAMINER'S NAME (Type) E. H. Adelman

Address (Street, city, town, or county)

DATE SIGNED 12-17-60

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF 12-23-60

22c. NAME OF CEMETERY OR CREMATORY Pleasant Grove Meth. Church

22d. LOCATION (City, town, or country) Marlboro, Md. (State)

23. FUNERAL DIRECTOR Morris A. Carter & Co. ADDRESS 305-H St. N.W. Wash. 1, D.C.

24a. REC'D BY REGISTRAR DATE DEC 28 '60

24b. REGISTRAR'S SIGNATURE Arthur S. Krause

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 7/59

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

13781

13751

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): La Plata
c. LENGTH OF STAY IN 1b:

2 USUAL RESIDENCE (Where deceased lived — If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X La Plata
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Physicians Memorial Hospital

3 NAME OF DECEASED (Type or print): First: Baby — Middle: Girl — Last: Moore

4. DATE OF DEATH: Month: Dec. — Day: 12, — Year: 1960

5 SEX: Female

6 COLOR OR RACE: W.

7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 12-12-60

9 AGE (In years last birthday): yrs

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS: Hours: Min: 30

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b KIND OF BUSINESS OR INDUSTRY: Infant

11. BIRTHPLACE (State or foreign country): Maryland

12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Sherwood Leslie Moore

14. MOTHER'S MAIDEN NAME: Lois Flater Bowie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO: No

17. INFORMANT: Mrs. Lois Moore — Address: La Plata, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): anoxia,
DUE TO (b): prematurity and inability of respiratory system to function —
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 762.5

INTERVAL BETWEEN ONSET AND DEATH: 10 min

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Hour: a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12/12/60, 19__, to 12/12/60, 19__, that (I) (we) last saw the deceased alive on [redacted] 19__, and that death occurred at 8:35 P.M., from the causes and on the date stated above

22a SIGNATURE: A. O. Wooddy M.D.

ATTENDING PHYS ☑ MED DIRECTOR ☐ STAFF PHYS ☐

22b DATE SIGNED: 13 Dec. 1960

22c PHYSICIAN'S NAME (Type): A. O. Wooddy, M.D.

22d ADDRESS: La Plata, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 12/15/1960

23c. NAME OF CEMETERY OR CREMATORY: Trinity Memorial Gardens

23d LOCATION (City, town, or county) (State): Waldorf, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Arehart Funeral Home, Inc. - La Plata, Md.

25a. REC'D BY REGISTRAR DATE: DEC 20 '60

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

VR A1S (4) 15M 9/59

2066201X

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files or its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health.

VS. A15ME
SM 2/57

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# 13782 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 14 Film G278 1-4-61 et

Reg. Dist. No. 13752

1. PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aquasco
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): none

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aquasco rural
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: William — Middle: Robert — Last: Moreland

4. DATE OF DEATH: Month: December — Day: 19 — Year: 1960

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 7 1902

9. AGE (In years last birthday): 58 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farmer
10b. KIND OF BUSINESS OR INDUSTRY: farming

11. BIRTHPLACE (State or foreign country): Charles Co. Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ELZAR Moreland

14. MOTHER'S MAIDEN NAME: Mary C. Burch

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Robert A. Moreland — Address: Waldorf, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma Stomach Cage — INTERVAL BETWEEN ONSET AND DEATH: 12-12-60

DUE TO (b): — 12-19-60

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: White at work ☐ Not white at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☐, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Edward J. Edelen M.D. M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): Edward J. Edelen M.D.

DATE SIGNED: 12-19-60

22a. BURIAL, CREMATION, REMOVAL (Specify): burial
22b. DATE THEREOF: 12-24-60
22c. NAME OF CEMETERY OR CREMATORY: ST. Peters Cemetery
22d. LOCATION (City, town, or county): Waldorf, Md. (State)

23. FUNERAL DIRECTOR'S SIGNATURE: Huntt Funeral Home
ADDRESS: Waldorf, Md.

24a. REC'D BY REGISTRAR DATE: DEC 27 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13783

## CERTIFICATE OF DEATH

Reg. Dist. No. 13753

1. PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Pomonkey~~ La Plata
c. LENGTH OF STAY IN 1b: [illegible]
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Physicians Memorial Hosp.LaPlata
d STREET ADDRESS: Md

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pomonkey-Md
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Edmund Middle Burt Last Owens

4. DATE OF DEATH: Month 12 Day 26 Year 19 60

5. SEX: Male
6. COLOR OR RACE: W-US
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5-3-1867
9. AGE (In years last birthday): 93 yrs.
IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Physician
10b. KIND OF BUSINESS OR INDUSTRY: Practice of Medicine
11. BIRTHPLACE (State or foreign country): Illinois
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Wesley Owens
14. MOTHER'S MAIDEN NAME: Mary Silverthorne

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): 1917-1919
16. SOCIAL SECURITY NO.: 219-05-4008
17. INFORMANT: Paul Keller-(Step Son — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Cardiac Decompensation — INTERVAL BETWEEN ONSET AND DEATH: 10-Days
DUE TO (b): Arterio-Sclerosis — Indefinite
DUE TO (c): Age

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10-1-60, 19__, to 12-26-60, 19__, that I last saw the deceased alive on 12-26-60, 19__, and that death occurred at 4-45 PM from the causes and on the date stated above.

ACTUAL SIGNATURE: James E. Andrews M.D. ADDRESS (Street, city or town, state): Indian Head Md. DATE SIGNED: 12-27-60

PHYSICIAN'S NAME (Type): James E. Andrews

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12-30-60
22c. NAME OF CEMETERY OR CREMATORY: Arlington National
22d. LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: The Huntt Funeral Home, Waldorf, Md.
24a. REC'D BY REGISTRAR DATE: JAN 3 '61
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1378

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 12754

1. PLACE OF DEATH
a. COUNTY: ~~Wicomico~~ Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Maryland~~ Wicomico
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Charles Co Md. — COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X ~~Charles Co Md.~~ Wicomico
d. STREET ADDRESS: --
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Barbara Regina Middle Last Powell
4. DATE OF DEATH: Month 12 Day 2 Year 19 60

5. SEX: F
6. COLOR OR RACE: C
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5/6/1950
9. AGE (In years last birthday): 10 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Newburg Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Robert V. Powell dec.
14. MOTHER'S MAIDEN NAME: Viola C. Powell dec.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Conflagration — INTERVAL BETWEEN ONSET AND DEATH: 12-2-60
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
916.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): House Fire
20c. TIME OF INJURY: Hour 7 a.m. p.m. Month, Day, Year 12-2 19 60
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) Wicomico (County) Chas (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☒ and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: E Modelen M.D.
EXAMINER'S NAME (Type): E. J. EDELEN
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 12-2-60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/5/60
22c. NAME OF CEMETERY OR CREMATORY: St Mary's
22d. LOCATION (City, town, or county) (State): Newport Maryland

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Johnson & Jenkins, 4804 Ga Ave N.W.
24a. REC'D BY REGISTRAR — DATE: DEC 6 '60
24b. REGISTRAR'S SIGNATURE: Cathryn L. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13785 Reg. Dist. No. 13755

**1. PLACE OF DEATH**
a. COUNTY: Wicomico Charles MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Charles Co/Md. Wicomico
c. LENGTH OF STAY IN 1b: life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Home

**2. USUAL RESIDENCE** (Where deceased lived. If Institution: Residence before admission)
a. STATE: Charles Co/ Md. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Charles/Co/Md/ Wicomico
d. STREET ADDRESS: --
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First James Middle HENRY Last Powell
4. DATE OF DEATH: Month 12 Day 2 Year 1960
5. SEX: M
6. COLOR OR RACE: C
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10/30/1948
9. AGE (In years last birthday): 12 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Newberg Md.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Robert V. Powell dec.
14. MOTHER'S MAIDEN NAME: Viola C. Powell dec.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT Address:

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Conflagration — INTERVAL BETWEEN ONSET AND DEATH: 12-2-60
DUE TO (b): //
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): 9 16.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): House Fire 12-2-60
20c. TIME OF INJURY: Hour 7 a. m. p. m. Month, Day, Year 12-2 1960
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) Wicomico (County) Chas (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: E. J. Edelen M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): E. J. EDELEN
DATE SIGNED: 12-2-60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/5/60
22c. NAME OF CEMETERY OR CREMATORY: St Mary's
22d. LOCATION (City, town, or county) (State): Newport Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Johnson & Jenkins 4804 Ga Ave N.W.
24a. REC'D BY REGISTRAR DATE: DEC 6 '60
24b. REGISTRAR'S SIGNATURE: Arthur L Keene

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 3 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13786

Reg. Dist. No. 12756

1. PLACE OF DEATH
a. COUNTY Wicomico Charles MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wicomico Maryland
c. LENGTH OF STAY IN 1b life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) --

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Charles Co Md. COUNTY Chas.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Charles Co Md. Wicomico
d. STREET ADDRESS --
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Joth Middle Allen Last Powell
4. DATE OF DEATH Month 12 Day 2 Year 1960

5. SEX M
6. COLOR OR RACE C
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 5/12/9151
9. AGE (In years last birthday) 9 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Baltimore Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Robert V. Powell dec.
14. MOTHER'S MAIDEN NAME Viola C. Powell dec.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion
916-0
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH 12-2-60

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Home Fall 12-2-60
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 12-2 1960
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home
20f. (City) or town (County) (State) Wicomico Chas Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE E J Edelen M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑
DATE SIGNED 12-2-60
EXAMINER'S NAME (Type) E. J. EDELEN

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 12/5/60
22c. NAME OF CEMETERY OR CREMATORY St Mary's
22d. LOCATION (City, town, or county) (State) Newport Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Johnson & Jenkins 4804 Ga Ave N.W.
24a. REC'D BY REGISTRAR DATE DEC 6 '60
24b. REGISTRAR'S SIGNATURE Arthur L Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files. Burial, Cremation, or removal.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar p

VS. A15ME(5)
5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# 13787 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 13757

1. PLACE OF DEATH
a. COUNTY Wicomico Charles MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Charles Co/Md. Wicomico
c. LENGTH OF STAY IN 1b life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Charles Co/ Md. COUNTY Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Charles Co/Md Wicomico
d. STREET ADDRESS --
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Joseph Middle A Last Powell
4. DATE OF DEATH Month 12 Day 2 Year 19 60
5. SEX M
6. COLOR OR RACE C
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 11/16/1957
9. AGE (In years last birthday) 3 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Norristown Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Robert V. Powell ###.
14. MOTHER'S MAIDEN NAME IDA Powell
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conflagration
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) 9160 DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH 12-2-60

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) House fire 12-2-60
20c. TIME OF INJURY Hour 9 a.m. p.m. Month, Day, Year 12-2 19 60
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home
20f. (City or town) Wicomico (County) Chas (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and find that death resulted from: Natural causes ☐, Accident ☑, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE E J Edelen M.D.
EXAMINER'S NAME (Type) E J EDELEN
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑
DATE SIGNED 12-2-60

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 12/5/60
22c. NAME OF CEMETERY OR CREMATORY St Mary's
22d. LOCATION (City, town, or county) (State) Newport Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Johnson & Jenkins 4804 Ga Ave N.W.
24a. REC'D BY REGISTRAR DATE DEC 6 '60
24b. REGISTRAR'S SIGNATURE Curtis L. Evans

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. Page 2 with the registrar prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar.

VS. A15ME(5)
5M 9/55

1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# 13788 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 12758

1. PLACE OF DEATH
a. COUNTY: Charles Co. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Charles Co Md. Wicomico
c. LENGTH OF STAY IN 1b: life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Wicomico Md. b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Charles Co Md Wicomico
d. STREET ADDRESS: --
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: RoBeRt Middle: Last: PoWeLL
4. DATE OF DEATH: Month: 12 Day: 2 Year: 1960
5. SEX: M
6. COLOR OR RACE: C
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5/3/1915
9. AGE (In years last birthday): 45 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Tobacco
11. BIRTHPLACE (State or foreign country): Newport Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Conflagration — INTERVAL BETWEEN ONSET AND DEATH: 12-2-60
DUE TO (b): House fire — 12-2-60
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☑ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): House fire
20c. TIME OF INJURY Hour: 2 a. m. p. m. Month, Day, Year: 12-2 1960
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, off ce bldg., etc.): Home
20f. (City or town) Wicomico (County) Chas (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☑, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: E. Edelen M.D.
EXAMINER'S NAME (Type): A. J. EDELEN
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑
DATE SIGNED: 12-2-60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/5/60
22c. NAME OF CEMETERY OR CREMATORY: St Mary's
22d. LOCATION (City, town, or county) (State): Newport Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Johnson & Jenkins 4804 Ga Ave N.W.
24a. REC'D BY REGISTRAR DATE: DEC 6 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Harris

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar of burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13789

Reg. Dist. No. 13759

1. a. COUNTY: Wicomico/ Charles — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Charles Co/ Md COUNTY Charles

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Charles Co/ Md/ Wicomico

c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Charles Co/ Md. Wicomico

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Home

d. STREET ADDRESS: --

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First VIOLA Middle Last POWELL

4. DATE OF DEATH: Month 12 Day 2 Year 1960

5. SEX: F

6. COLOR OR RACE: C.

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5/3/1915

9. AGE (In years last birthday): 45 yrs.

IF UNDER 1 YEAR: Months / Days

IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Newport Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Address

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Conflagration — INTERVAL BETWEEN ONSET AND DEATH: 12-2-60

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): House fire 12-2-60

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. Month, Day, Year: 1am 12-2 1960

20d. INJURY OCCURRED: While at work ☐ Not while at work ☑

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) (County) (State): Wicomico Chas Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and find that death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: E. J. Edelen M.D.

EXAMINER'S NAME (Type): E. J. EDELEN

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑

DATE SIGNED: 12-2-60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12-5-60

22c. NAME OF CEMETERY OR CREMATORY: St Mary's Co

22d. LOCATION (City, town, or county) (State): Newport Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Johnson & Jenkins 4804 Ga Ave N.W.

24a. REC'D BY REGISTRAR DATE: DEC 6 '60

24b. REGISTRAR'S SIGNATURE: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be returned for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

13790

Reg. Dist. No. 13760

1. PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Newburg (Rural)
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Newburg (Rural)
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Laura — Middle: — Last: Rogers

4. DATE OF DEATH: Month: Dec. — Day: 16 — Year: 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 8 1887

9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Dent

14. MOTHER'S MAIDEN NAME: Fanie Madden

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Address: Ethel Rogers Newburg, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Massive Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 12-16-'60

331X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Hypertension — 1953

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

20f. (City or town) (County) (State):

21. I certify that I attended the deceased from Dec. 153, to Dec. 16, 1960, that I last saw the deceased alive on Dec. 15, 1960, and that death occurred at 6:30 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: E. J. Edelen M.D. — ADDRESS (Street, city or town, state): La Plata, Md. — DATE SIGNED: 12-19'60

PHYSICIAN'S NAME (Type): E. J. Edelen, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12-19-60

22c. NAME OF CEMETERY OR CREMATORY: Mt Rest Cemetery

22d. LOCATION (City, town, or county) (State): La Plata, Md

23. FUNERAL DIRECTOR'S SIGNATURE: Hurst Funeral Home Inc. by M — ADDRESS: La Plata, Md

24a. REC'D BY REGISTRAR: DATE DEC 22 '60

24b. REGISTRAR'S SIGNATURE: Irma S. Kane

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death

VS. A15ME 5M 7/59

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 13791 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13261

1. PLACE OF DEATH
a. COUNTY Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Issue
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE Maryland b. COUNTY Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Issue
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print) First RICHARD Middle Last TEMPLEMAN

4. DATE OF DEATH Month 12 Day 8 Year 1960

5. SEX M

6. COLOR OR RACE C

7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH 1-15-02

9. AGE (In years last birthday) 55 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer

10b. KIND OF BUSINESS OR INDUSTRY On Farm

11. BIRTHPLACE (State or foreign country) Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME WALTER TEMPLEMAN

14. MOTHER'S MAIDEN NAME ANNA GANNON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No

16. SOCIAL SECURITY NO. Yes/

17. INFORMANT Address CHURCH Record

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LUNG HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH 12-5-60

DUE TO (b) UNKNOWN — 12-8-60

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [ ], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE E. J. Dellon M.D.

EXAMINER'S NAME (Type) E. J. DELLON

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

Address (Street, city, town, or county)

DATE SIGNED 12-8-60

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF 12/12/1960

22c. NAME OF CEMETERY OR CREMATORY Holy Ghost Cemetery

22d. LOCATION (City, town, or country) Issue (State) Maryland

23. FUNERAL DIRECTOR ADDRESS Arehart Funeral Home, Inc. La Plata, Md.

24a. REC'D BY REGISTRAR DATE DEC 20 '60

24b. REGISTRAR'S SIGNATURE Catherine L. Krause

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13792

## CERTIFICATE OF DEATH

Reg. Dist. No. 13762

1. PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bryantown
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bryantown
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Alice — Middle: Lorretta — Last: Thompson

4. DATE OF DEATH: Month: Dec — Day: 6 — Year: 1960

5. SEX: Female — 6. COLOR OR RACE: Negro — 7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: Dec 5, 1960 — 9. AGE (In years last birthday) yrs. — IF UNDER 1 YEAR: Months — Days: 1 — IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant — 10b. KIND OF BUSINESS OR INDUSTRY: — 11. BIRTHPLACE (State or foreign country): Maryland — 12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Lewis Walter Thompson — 14. MOTHER'S MAIDEN NAME: Edith Mavie Thompson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO: NONE
INFORMANT: Lewis W. Thompson — Address: Bryantown, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 762.5 — Respiratory impairment — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs.
DUE TO (b): Prematurity — 24 hrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour o. m. p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12-5, 1960 to 12-6, 1960 that I last saw the deceased alive on 12-6, 1960, and that death occurred at 11:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: F M Johnson M.D. — ADDRESS (Street, city or town, state): LA PLATA, Md. — DATE SIGNED: 7 Dec 60

PHYSICIAN'S NAME (Type): F M. JOHNSON M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 12-7-60 — 22c. NAME OF CEMETERY OR CREMATORY: St Marys — 22d. LOCATION (City, town, or county) (State): Bryantown Md.

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: The Huntt Funeral Home, Waldorf, Md.

24a. REC'D BY REGISTRAR DATE: DEC 12 '60 — 24b. REGISTRAR'S SIGNATURE: Arthur L. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VII A15 (4)
15M 9/58

4000212

1

**FOR STATE HEALTH DEPT.**

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 13793 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13763

1. PLACE OF DEATH
a. COUNTY Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Charlotte Hall Rural)
c. LENGTH OF STAY IN 1b Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE Md
b. COUNTY CHAS.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHARLOTTE HALL (RURAL)
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print) First: MARGARET Middle: LENORA Last: WHALEN

4. DATE OF DEATH Month: 12 Day: 14 Year: 1960

5. SEX: F

6. COLOR OR RACE: C

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 10-19-60

9. AGE (In years last birthday) yrs. X — IF UNDER 1 YEAR Months — Days 26 — IF UNDER 24 HRS Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph FANNON WHALEN JR

14. MOTHER'S MAIDEN NAME: ANNE CHRISTINE BAKER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wer or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT Address: 11 Charlotte Hall Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 12-12-60
DUE TO (b): J-91X — 12-14-60
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II. of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X] and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE, M.D: C. A. Bolden

EXAMINER'S NAME (Type): C. A. BOLDEN

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
Address (Street, city, town, or county)

DATE SIGNED: 12-14-60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12/15/1960

22c. NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery

22d. LOCATION (City, town, or country) (State): Newport, Maryland

23. FUNERAL DIRECTOR ADDRESS: Arehart Funeral Home, Inc. - La Plata, Md.

24a. REC'D BY REGISTRAR DATE: DEC 20 '60

24b. REGISTRAR'S SIGNATURE: [signature]

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 7-59

Arehart Funeral Home, Inc. - La Plata, Md.

L 10214 X V 5

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13794

## CERTIFICATE OF DEATH

13764

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Charles — MARYLAND
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Charles
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Waldorf rural
c. LENGTH OF STAY IN 1b:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Waldorf rural
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: none
d. STREET ADDRESS:
IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First Frances — Middle Marie — Last Willett
4. DATE OF DEATH: Month Dec. — Day 21 — Year 1960
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: March 29 1889
9. AGE (In years last birthday): 71 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): house work
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (State or foreign country): Charles Co. Md.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Andrew M. Gates
14. MOTHER'S MAIDEN NAME: Florence Canter
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: none
17. INFORMANT: Mrs. Marie Adell — Address: Accokeek, Md.

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): ARDIO-RENAL Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 4 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Cardio-Vas-Renal Dis & Hypertension — 4 yrs

DUE TO (c): Senility

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. / p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from 1950 19__, to 12-21 1960 that (I) (we) last saw the deceased alive on 12-19 1960, and that death occurred at 3 A.M. from the causes and on the date stated above.

22a. SIGNATURE: George Weber M.D.
ATTENDING PHYS [X] MED DIRECTOR [ ] STAFF PHYS [ ]
22b. DATE SIGNED: 12-22-60
22c. PHYSICIAN'S NAME (Type): George Weber M.D.
22d. ADDRESS: Waldorf, Md.

23a. BURIAL CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Dec. 23 1960
23c. NAME OF CEMETERY OR CREMATORY: Oakland Cemetery
23d. LOCATION (City, town, or county) (State): Waldorf, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Huntt Funeral Home — ADDRESS: Waldorf, Md.
25a. REC'D BY REGISTRAR — DATE: DEC 27 '60
25b. REGISTRAR'S SIGNATURE: Arthur L. Hines

VR A1S (4)
15M 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

13795

Reg. Dist. No. 13765

1. PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Marbury
c. LENGTH OF STAY IN 1b: . .
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Marbury
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MARY Middle: VIRGINIA Last: Wills

4. DATE OF DEATH: Month: 12 Day: 17 Year: 1960

5. SEX: F

6. COLOR OR RACE: C

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12-17-60

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months | Days | IF UNDER 24 HRS.: Hours | Min. 20

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Lewis Wills

14. MOTHER'S MAIDEN NAME: Gracie Rebecca Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT Address: Mr. Joseph L. Wills - Potomac Heights, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Unknown - probable
DUE TO (b): Mother had Pneumonia
DUE TO (c): Separation of Placenta

Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 12-17-60

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Brought to Hospital with head, severe & fatal placenta.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____M, from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D.
ADDRESS (Street, city or town, state): La Plata Md
DATE SIGNED: 12-18-60

PHYSICIAN'S NAME (Type): W. S. EDELEN

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12/18/1960

22c. NAME OF CEMETERY OR CREMATORY: Shilo Methodist Cemetery

22d. LOCATION (City, town, or county) (State): Mt. Victoria, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: [signature]
ADDRESS: Arehart Funeral Home, Inc. *La Plata, Md.

24a. REC'D BY REGISTRAR DATE: DEC 30 '60

24b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relied upon by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the [illegible] director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

400023 4XV5

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13796 Reg. Dist. No. 13766

1. PLACE OF DEATH
a. COUNTY Wicomico Charles MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Charles Co Md. Wicomico
c. LENGTH OF STAY IN 1b life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Charles Co Md. COUNTY Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Charles Co Md Wicomico
d. STREET ADDRESS --
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Philip Middle C Last Yates
4. DATE OF DEATH Month 12 Day 2 Year 19 60
5. SEX M
6. COLOR OR RACE C
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 9/25/1949
9. AGE (In years last birthday) 11 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Newburg, Charles Co Md.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Unknown
14. MOTHER'S MAIDEN NAME Betty Powell
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no
16. SOCIAL SECURITY NO.
17. INFORMANT Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conflagration — INTERVAL BETWEEN ONSET AND DEATH 12-2-60
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
916.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) House fire 12-2-60
20c. TIME OF INJURY Hour a. m. Month, Day, Year 12-2 19 60
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE E.J. Edelen M.D.
EXAMINER'S NAME (Type) E.J. Edelen
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 12-2-60

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 12/5/60
22c. NAME OF CEMETERY OR CREMATORY St Mary's
22d. LOCATION (City, town, or county) (State) Newport Maryland
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Johnson & Jenkins 4804 Ga Ave N.W.
24a. REC'D BY REGISTRAR DATE DEC 6 '60
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55